tensive defects. The hospital stay is reduced by this technique and the patient is spared weeks of uncomfortable immobilization.

Thumb and finger reconstruction by toe transplantation, once a medical curiosity, is being done with increasing frequency. The expanding interest in the field of microsurgery will bring about simplification of techniques and more dependable results.

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REFERENCES

Report of American Replantation Mission to China: Replantation surgery in China. Plast Reconstr Surg 52:476, Nov 1973

O'Brien BM, Miller GD: Digital reattachment and revascularization. J Bone Joint Surg 55A:714-724, Jun 1973

Buncke HJ. McLean DH, George PY: Thumb replacement, great toe transplantation by microvascular anastomosis. Br J Plast Surg 26:194-201, Jul 1973

Harri K, Ohmori K, Ohmori S: Successful transfer of ten free flaps by microvascular anastomoses. Plast Reconstr Surg 53:259, 1974

The Eye in Facial Palsy

TODAY, treatment of facial palsy only rarely requires that a deforming central tarsorrhaphy—formerly a common procedure to protect the cornea from dust and dry air—be done. The early intervention of a reconstructive plastic surgeon, with occasional assistance from a soft contact lens fitted by an ophthalmologist, provides ocular protection without creating highly visible deformity.

The condition treated is the abence of the closing force of the orbicularis worsened by the lively action of the levator (lifter) of the upper lid, which now has no antagonist.

The diverse therapeutic choices include operations to support and horizontally shorten the lower lid (some taken from antiquity resemble old operations for the correction of senile ectropion in the central, medial or lateral lid). Other approaches support the lid by use of autogenous or preserved fascia lata graft supports in the pretarsal lower lid, with the delicate assistance of a Scottish lateral tarsorrhaphy to join the upper and lower tarsal plates so the lower lid will rise with the upper and therefore look alive. Such fascial slings often accompany procedures to support the rest of the face.

To antagonize the levator and allow the lid to fall when it relaxes, as in downward gaze or blinking, a weight of gold can be placed in the upper lid to use the force of gravity. More active, and risky, is the use of a stainless steel spring in the upper lid for the same purpose or a fine silicone rubber band around both lid edges which holds the lids closed when the levator is not working. A more active and useful upper lid can be achieved in these ways.

Temporal muscle transfers to replace the orbicularis occasionally work well but frequently fail to achieve a good functional and cosmetic result. Free muscle grafts reportedly work to some extent but are experimental still—as is the use of magnets. The deformity is such that patients are often more than willing to become parties to experimentation.

The options are many; none is entirely satisfactory. The decision as to method of treatment should be made by those with special training, interests and skills in the subject.

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REFERENCES

Jobe R: A technique for lid loading in the management of lagophthalmos of facial palsy. Plast Reconstr Surg 53:29, Jan 1974

Arion HG: Dynamic closure of the lids in paralysis of the orbicularis muscle. Int Surg 57:48-50, Jan 1972

Morel-Fatio D, Lalardrie JP: Palliative surgical treatment in facial paralysis. Plast Reconstr Surg 33:466, May 1964